HEALTH QUALITY ONTARIO

2012–13 ANNUAL REPORT

Ontario
Health Quality Ontario

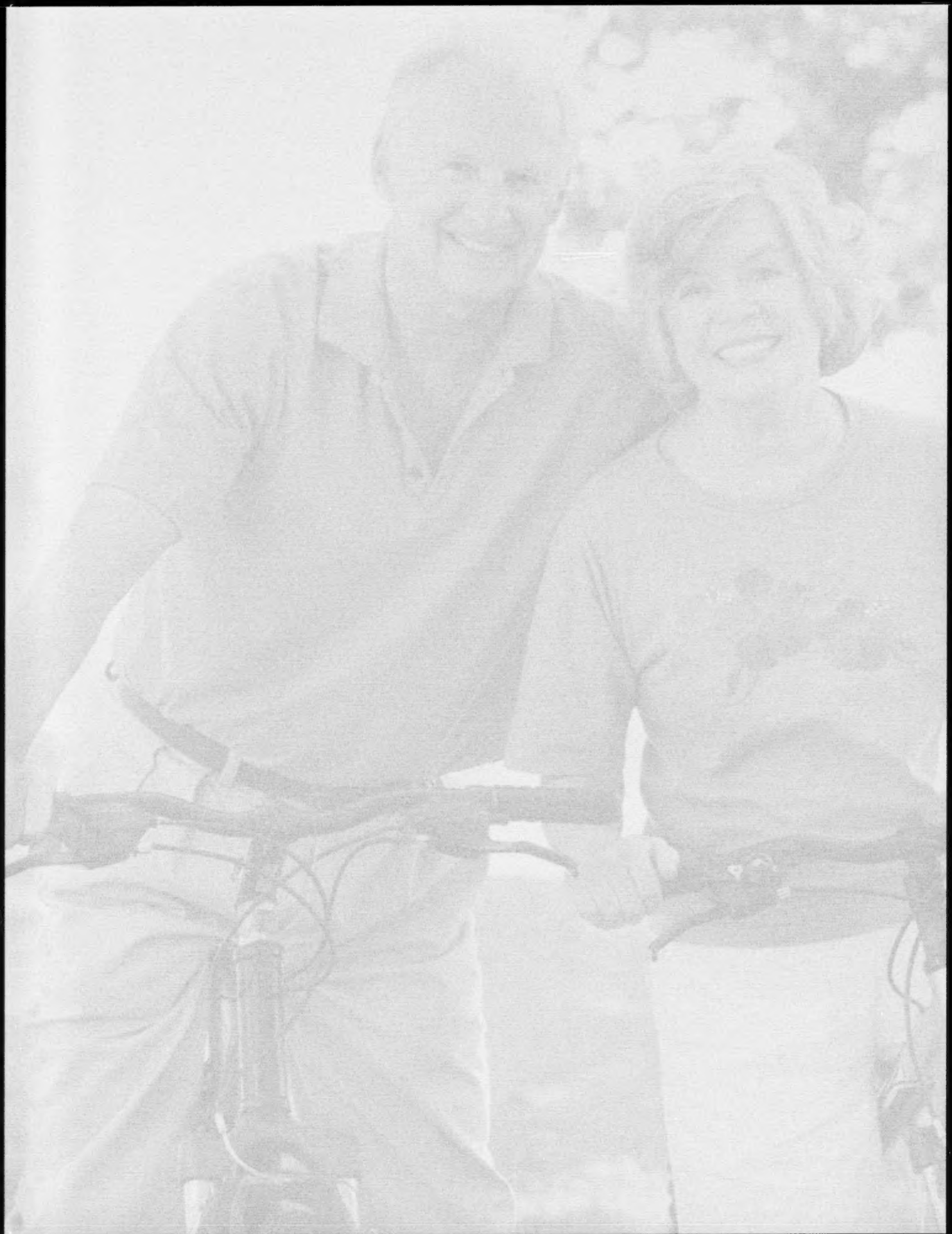


Table of Contents

Transmittal Letter to the Minister 4

Message from HQO's Board Chair & Interim President & Chief Executive Officer 5

Organization Overview 6

Vision, Mission, Values 8

Evidence Development and Standards 9

Integrated Programs 11

Quality Improvement Programs 12

Public Reporting 15

Engaging our Partners 17

Performance Measures and Financial Performance 18

Governance 19

Conclusion 20

Compendium: Summary of 2012-13 Evidence-Based Recommendations 21

Independent Auditor's Report Financial Statements 33

Ontario
Health Quality Ontario

Tuesday, June 25, 2013

The Honourable Deb Matthews
Minister of Health and Long-Term Care
Hepburn Block
80 Grosvenor Street, 10th Floor
Toronto, Ontario M7A 2C4

Re: Health Quality Ontario 2012-13 Annual Report

Dear Minister Matthews:

On behalf Health Quality Ontario (HQO)'s Board of Directors, we are pleased to submit to you HQO's 2012-13 Annual Report. The report outlines our activities during the past fiscal year, as well as our audited financial statements.

This annual report is in accordance with the requirements as outlined in the Accountability Agreement and our Memorandum of Understanding, and fulfills our obligations under the Agency Establishment Accountability Directive.

We appreciate your continued support for HQO's work.

Respectfully,

Dr. Andreas Laupacis
Chair, Board of Directors
Health Quality Ontario

Mark Rochon
Interim President & Chief Executive Officer
Health Quality Ontario

Message from HQO's Board Chair & Interim President & Chief Executive Officer

Health Quality Ontario (HQO) is pleased to present our 2012-13 Annual Report. This marks the second year that HQO has been operating as Health Quality Ontario under its broadened mandate.

Over the past two years, HQO has positioned itself as a provincial leader and partner for improving the care Ontarians receive. With a focused, integrated, provincial approach to evidence development, quality improvement, and public reporting, HQO works with health system partners to ensure that Ontarians receive health care that represents the best quality. Underpinning that aim is our work to ensure that Ontario's health system is sustainable – so that future generations have access to high-quality care.

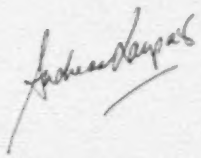
We strive to provide leading expertise in evidence, quality improvement and reporting, and in doing so continually advance evidence-based practices that anticipate and respond to client and system needs.

In the past year, we have continued to focus on building our organization and relationships with our funder, the Ministry of Health and Long-Term Care and our partners – health care system leaders and providers – who day-to-day deliver care to Ontarians.

Better integration is critical for the system as a whole if it is to be sustainable. For that reason, in the coming year some of our resources will be repositioned, in particular our quality improvement support, to align with the ministry's transformation agenda. In addition to developing a health system reporting framework, we recognize the need to focus some of our support to address high priority areas, namely, the top five percent of Ontarians, who are in significant need of health care services[1], and in support of the Government of Ontario's Health Links initiative[2].

We would like to take this opportunity to acknowledge Marie Fortier who acted as Interim Board Chair during this past year. We are grateful for her guidance through this period of transition and her genuine passion for our organization's mandate.

A vision for health system transformation is at the core of our work at HQO. On behalf of the board, we thank our funders at the Government of Ontario for their stewardship and support. We look forward to advancing evidence-based health care, quality improvement across the system and reporting to Ontarians on the progress in the years ahead.



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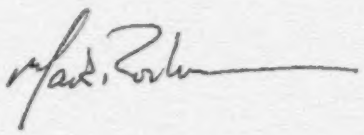
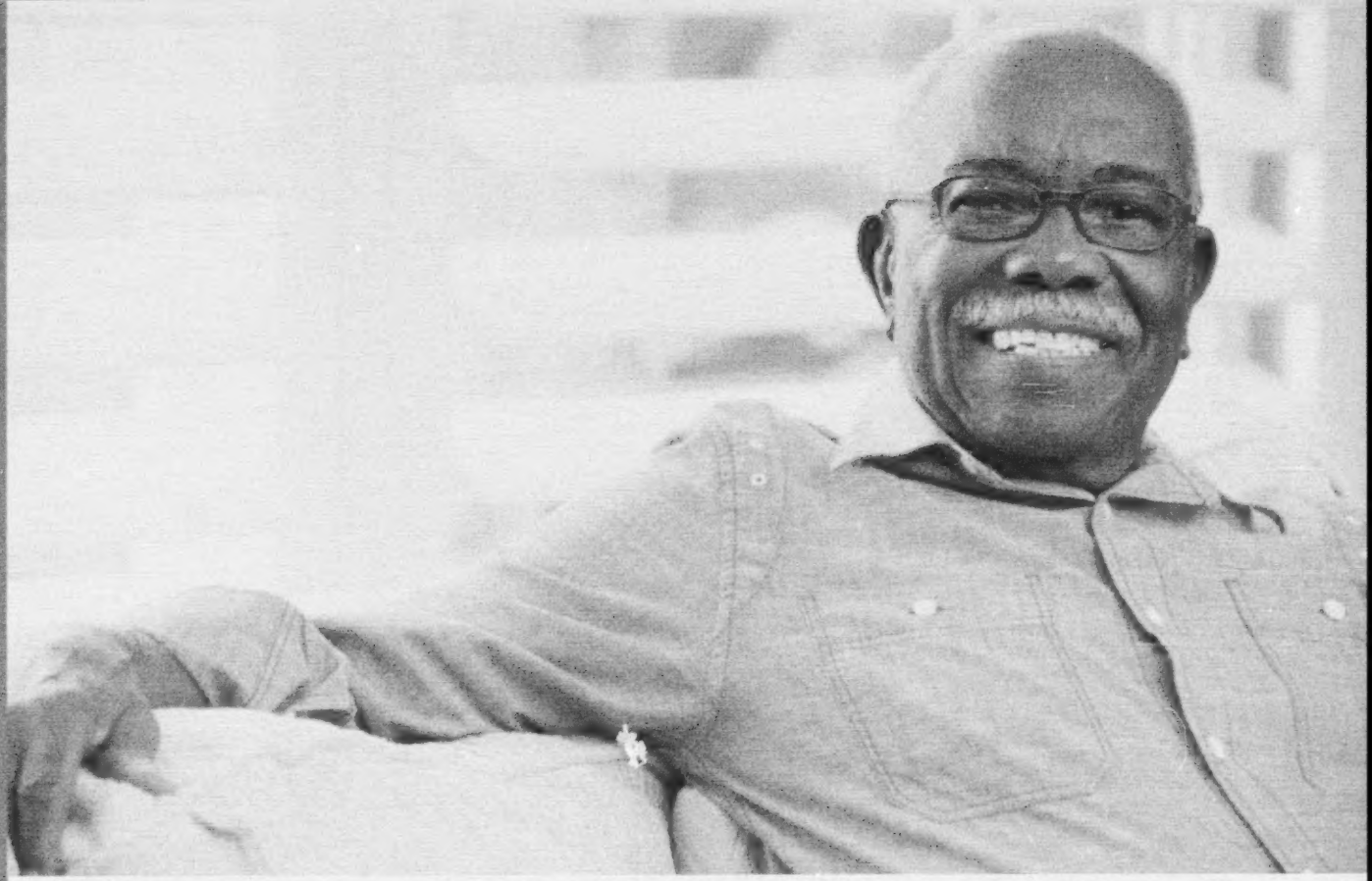


Mark Rochon
Interim President & Chief Executive Officer
Health Quality Ontario

1 "Patients with the greatest health care needs make up five percent of Ontario's population but use services that account for approximately two-thirds of Ontario's health care dollars." Ontario Ministry of Health and Long-Term Care (December 6, 2012) *Backgrounder: About Health Links.* Retrieved from http://news.ontario.ca/mohltc/en/2012/12/about-health-links.html

2 Health Links is an initiative of the Government of Ontario developed to bring together health care providers in a community to better and more quickly coordinate care for high-needs patients. Ontario Ministry of Health and Long-Term Care (December 6, 2012) Backgrounder: *About Health Links.* Retrieved from http://news.ontario.ca/mohltc/en/2012/12/about-health-links.html



Organization Overview

Health Quality Ontario (HQO) works in partnership with Ontario's health care system to support a better experience of care, better outcomes for Ontarians and better value for money. Health Quality Ontario's legislated mandate under the *Excellent Care for All Act*, 2010, is to evaluate the effectiveness of new health care technologies and services, report to the public on the quality of the health care system, support quality improvement activities, and make evidence-based recommendations to assist health system funding reform.

To support this mandate, HQO has consulted with health system stakeholders, including our funder, the Ministry of Health and Long-Term Care (the ministry), to inform our work. Health Quality Ontario is beginning the work necessary to meet the needs of our clients by sharpening our focus. Our work leverages partnerships, integrates our resources and delivers on our mandate by supporting health care system transformation and, more specifically, focusing on the priorities outlined in Ontario's Action Plan for Health Care.

Health Quality Ontario's work in evidence development strives to promote health care that is supported by the best available scientific evidence. We work with clinical experts, scientific collaborators and field evaluation partners to conduct evidence-based analyses to evaluate the effectiveness and cost-effectiveness of health technologies and services in Ontario. Responding to health system requests, including those of the ministry, HQO meets key health system priorities by supporting evidence-based practices across Ontario.

Accelerating quality improvement at the provincial/system level is a key priority for HQO. In the past, direct front-line engagement was a focus for our quality improvement work. In the future, HQO will take on the much-needed advisor role and move from sector-based initiatives to integrated programs that extend the reach and impact of these efforts.

Our mandate includes objectively monitoring and publicly reporting to Ontarians on how well their health care system is performing. The annual release of Quality Monitor, our yearly report on the state of Ontario's health system, is a key component of fulfilling this mandate. Health Quality Ontario is adjusting its approach to online reporting and the Quality Monitor to better meet the needs of a varied audience and maximize the value we deliver to the public.

Partnerships enable us to monitor and report on system progress, create evidence and promote its uptake, and develop and deploy the tools and knowledge necessary to expand our reach. Over the past year, HQO developed a Strategic Partnership Framework that outlines how we initiate, strengthen and nurture relationships with external partners.

This was the first year that HQO delivered Health Quality Transformation, an event that played a critical role in bringing together over 700 leaders, providers, researchers, government and other key stakeholders from across Ontario's health care system to work together on a common quality agenda.

Executing these mandated activities requires a solid foundation of shared support services. In the past year, HQO has built a strong support services infrastructure that includes specialist resources. These teams facilitate key aspects of health system integration and transformation through their best practice approaches to knowledge creation and distribution, leveraging partners' expertise, and acquiring and interpreting data.

Just as we measure the performance of the health system, HQO has created a performance measurement framework to measure the impact of our own work. This standardized approach continuously captures our progress and HQO will be adding new indicators throughout the coming fiscal year.

Also in the coming year, we will continue to deliver on our mandate and prioritize our initiatives to address key areas for change. This includes focusing some of our resources to help address key priority areas, including the top five percent of Ontario's health care system users and to support the Government's Health Links initiative.

Vision, Mission, Values

Vision

A health care system that is sustainable, improves continually and uses evidence to optimize population health and provide excellent care for all Ontarians.

Mission

A catalyst for quality, an independent source of information on health evidence, a trusted resource for the public.

Values

- Transparency
- Passion
- Innovation
- Learning
- Integrity
- Collaboration

Transformative Objectives

- Accelerate the use of evidence to deliver demonstrable improvements in the quality of health services
- Drive a culture of quality, value and accountability throughout the health system in Ontario
- Forge partnerships and advance integration among the distinct components of the health system

Overarching Aim(s)

- Better outcomes, better experience, better value for money

Our Roles

- Focus the system on a common quality agenda: Establish priorities, goals and targets, and mobilize system leadership around a common agenda to maximize impact for Ontarians.
- Build evidence and knowledge: Generate or access the evidence and knowledge needed to provide quality care and improve population health, including funding recommendations that set expectations for quality.
- Broker improvement: Develop the tools and supports needed to accelerate the adoption of evidence-based best practice. Foster the development of quality improvement capacity in the system.
- Catalyze spread: Guide, support and collaborate within the system to spread knowledge about best practices, measurement tools, and implementation strategies. Embed best practices into standards.
- Evaluate progress: Demonstrate accountability by providing timely and relevant health system monitoring, measurement and reporting. Assess progress and report to the public.

Evidence Development and Standards

Care across the province should be patient-centred, driven by a quality framework that promotes optimal outcomes and based on the best scientific evidence. Health Quality Ontario's Evidence Development and Standards (EDS) branch works with clinical experts, scientific collaborators and field evaluation partners to conduct evidence-based analyses to evaluate the effectiveness of health technologies and services and their cost-effectiveness to help identify how finite health dollars should be used to best serve Ontarians.

The evidence component of HQO's work includes the following types of reviews:

- **Evidence-Based Analyses:** Systematic reviews using evidence from scientific literature and supplemented by expert panels, as necessary, where there is sufficient data to evaluate the effectiveness, safety and cost-effectiveness of a single technology.
- **Mega-Analyses:** A broader review that evaluates the safety, efficacy, and cost-effectiveness of multiple interventions for a given condition.
- **Rapid Responses:** Take the form of a brief, preliminary overview of the existing evidence and are conducted within a two-week timeframe.
- **Appropriateness:** Evidence-based analyses and recommendations that discourage the overuse, underuse or misuse of health technologies and services in Ontario.

In 2012-13, the ministry asked HQO to identify $150 million in health system savings. Our Appropriateness work, completed in partnership with the Ontario Medical Association, exceeded that target by 169%. If all 19 recommendations made by HQO are successfully implemented the health system can avoid $254 million in costs, which can then be directed to other areas of need.

Ontario Health Technology Advisory Committee

Based on the results of HQO's evidence-based analyses, the Ontario Health Technology Advisory Committee (OHTAC), a standing advisory committee of HQO's Board of Directors, prepares advice about the uptake, diffusion, distribution or removal of health interventions to the ministry, clinicians, health system leaders and policymakers. Recommendations made during 2012-13 are listed in the Compendium section of this report.

In 2012-13, HQO completed an implementation framework that will be used to generate high-level implementation suggestions to support the uptake of HQO's evidence-based analyses and recommendations. Developed in collaboration with the ministry, the framework will enable HQO to meet the high-level policy and planning needs of its stakeholders.

Health Quality Ontario's field evaluations program evaluates health interventions in real-time clinical settings. These studies are conducted when the original evidence-based analysis finds insufficient evidence on the safety, effectiveness or cost-effectiveness of a health technology of service.

To track the diffusion of OHTAC-reviewed health interventions over time and by Local Health Integration Network (LHIN), HQO produces the Ontario Health Technology Maps Report. The results of this report have been used to facilitate changes in practice patterns to align care with evidence across the province.

Evidence-Based Episodes of Care

Our Evidence Development and Standards branch also contributes to health system funding reform through the development of evidence-based episodes of care linked to procedures reimbursed on an activity basis. In the past year, work in this area was initially focused on four conditions: congestive heart failure, stroke, chronic obstructive pulmonary disease and hip fractures. Based on this work, HQO made recommendations about how to define a bundle of services for patients with these conditions while they are in hospital and after discharge. Development of complementary quality performance indicators is a future area of work that will begin once clinical handbooks are finalized and submitted to the ministry.

Other highlights of the branch's work in 2012-13 include HQO taking over outstanding deliverables associated with the orthopedic expert panel and a summary of proposed processes for the dissemination of health standards.

The work of the EDS branch provides the health system with centralized, evidence-based capacity that ensures a consistent approach to uptake and diffusion of new health technologies and services. During 2012-13, the EDS team expanded in response to increasing demands for ministry-requested products, including Quality Based Procedures, Appropriateness work and other health system requests.

In the coming year, this area of work will intersect with HQO's quality improvement and public reporting initiatives to broaden the impact of these recommendations by setting standards and publicly reporting outcomes.

Optimizing Chronic Disease Management in the Community

Health Quality Ontario is conducting a mega-analysis to answer the question, "What evidence-based community services are effective and cost-effective for optimizing chronic disease management among adults?" The focus of this analysis is adults with at least one of the following high-burden chronic conditions: chronic obstructive pulmonary disease, coronary artery disease, atrial fibrillation, heart failure, stroke, diabetes or chronic wounds. By the end of the fiscal year, this substantive work was posted for public comment.

Partnerships

Partnerships are critically important to this undertaking and as such HQO has forged strong partnerships with leaders in the field, including the Institute for Clinical and Evaluative Sciences, the Centre for Health Economics and Policy Analysis, the Programs for Assessment of Technology in Health Research Institute, the Toronto Economics and Technology Assessment Collaborative, and the Ontario Clinical Oncology Group among others.

A member of the International Network of Agencies for Health Technology Assessment, HQO evaluates evidence-based analyses from across the world. Health Quality Ontario has formed collaborations with the Ottawa Research Institute, Li Ka Shing Knowledge Institute, the University Health Network, and London Health Sciences Centre.

Integrated Programs

Health Quality Ontario is committed to transformational change for Ontario's health system. To ensure success, HQO's work is rooted in collaboration with our health system partners. Our work supports integrated and coordinated efforts across all sectors of Ontario's health care system.

Our quality improvement programs focus on system support and effectiveness. Sector-specific programs such as Residents First and Advanced Access, Efficiency and Chronic Disease Management are recognized as successful programs with a notable role in advancing quality improvement in Ontario. Future work includes developing scalable business models to accelerate quality improvement at the system level, particularly Health Links, and moving away from direct front-line engagement in our quality improvement efforts to take on an advisory role, enabling our organization to support more work on a larger scale.

Quality Improvement Plans

Health Quality Ontario provides support, strategic direction and expertise for the development of Quality Improvement Plans (QIPs) and provides a coordinated, evidence-based approach to support the implementation of QIPs across the health care system.

The development and public reporting of annual QIPs is a requirement under the *Excellent Care for All Act*, 2010. Implementation of QIPs began with hospitals and will be expanding to other sectors across the health care system in the coming years. QIPs provide an important vehicle for the alignment of provincial, regional and local priorities and a shared quality agenda.

Health Quality Ontario is responsible for annual QIP submission intake, conducting an in-depth analysis, and providing feedback to help build capacity and improve performance on priority indicators. During the first two years of QIP submissions there were issues regarding data quality and inconsistency. To support hospitals and address these issues,

in 2012-13, HQO developed an online submission tool, the QIP Navigator. This tool standardizes the data entry enabling HQO to conduct more comprehensive reporting and provide feedback that is more detailed. In its first year of operation, nearly 63% of hospitals voluntarily used the tool to submit their QIPs. HQO anticipates that as adoption of the tool becomes more commonplace, reporting quality will improve, as will analysis and feedback.

Health Quality Ontario provided further supports to Ontario hospitals to assist them with future quality improvement work including a 2012-13 QIP Analysis for Improvement Report. Health Quality Ontario worked with its partners and funder to support the field by providing QIP guidance documents, common templates, indicator data reporting periods and recommended benchmarks.

In 2012-13, HQO developed a strategic framework to outline the necessary work required to support QIPs for the primary care sector and proposed a framework for recognizing the work of top performers. Health Quality Ontario supported the introduction of QIPs to the primary care sector to enable Aboriginal Health Access Centres, Community Health Centres, Family Health Teams and Nurse Practitioner Led Clinics to submit QIPs by the April 1, 2013 deadline.

QIPs are a strong capacity-building vehicle. Health Quality Ontario is committed to ensuring that our involvement aligns with health system priorities, especially considering the scope of this work may change in the future when all sectors are required to submit their QIPs to HQO.

Quality Improvement Programs

bestPATH

bestPATH is a support for Health Links communities across the province, enabling health care providers to improve health care coordination, care experiences and outcomes for those with complex health conditions. In 2012-13, HQO undertook the work of planning and developing a comprehensive curriculum that would meet the needs of this cross-sector program. Drawing on rigorously reviewed evidence, field experience and measurement and evaluation

methodology, HQO developed the bestPATH improvement packages on transitions of care, chronic disease management, and supporting health independence.

In addition, HQO led and participated in three events in 2012-13: the North Simcoe Muskoka LHIN Community Care Engagement Workshop, the South East LHIN Primary Care Workshop: Health Links and HQO Resources, and Central LHIN's Full Day Patient and Family Engagement Workshop with over 175 participants.

Advanced Access, Efficiency & Chronic Disease Management

Building on consecutive quality improvement initiatives since 2008, HQO's Advanced Access, Efficiency & Chronic Disease Management initiative is a primary care-focused improvement initiative. The initiative has a curriculum with access and efficiency (helping primary care practices streamline their operations to reduce wait times for patients) at its core, with an additional focus on chronic disease management. The program supports three strategic areas in primary care quality improvement plans: timely care (same/next day access to a primary care provider); reducing emergency department use for conditions best managed elsewhere (by increasing access to a primary care provider); and reducing hospital readmissions (by improving access to primary care and chronic disease management). Improvement packages were developed to support quality improvement work in the areas of advanced access and efficiency for practices, chronic obstructive pulmonary disease, asthma, hypertension, diabetes, and integrated cancer screening.

In 2012-13, 275 teams participated in waves 4 and 5 of the Advanced Access, Efficiency & Chronic Disease Management initiative and 465 providers received training in quality improvement. Commitment to the initiative is high, with 89% of the teams choosing to continue to be engaged. Health Quality Ontario also conducted an external evaluation of the first four waves of the program and launched wave 5 and 6 of the program. As a result, 82 primary care practices participating in the initiative improved wait times by nearly 50%. These waves are supported by communities of practice that provide an online network that aims to sustain the gains made throughout the initiative. Further, On the Road, a continuing medical education program, was developed in conjunction with machealth (McMaster University) and the Ontario College of Family Physicians. Using an e-learning strategy, small group facilitated learning, and a mentoring/coaching network, this program continues to reach practices across the province. Health Quality Ontario anticipates that, through this program, we will be able to double the number of practices we are able to reach each year.

Residents First

Residents First, a five-year (2009-14) provincial quality improvement strategy for long-term care homes, continued to deliver support across the province for quality improvement initiatives, and towards sustaining and spreading the achieved improvement. The initiative supports quality in long-term care as measured across a variety of core, internationally validated, and publicly reported indicators. Health Quality Ontario worked with long-term care homes on quality improvement projects focusing on priority areas such as falls, pressure ulcers, continence, reduced emergency department utilization, consistency of personal support worker assignment and general quality improvement.

Engagement in the initiative remains high, with 81 homes participating and 444 providers and staff trained in quality improvement. Since the program began, Residents First has trained over 1,260 individuals to use the knowledge and tools of the program to implement improvements, with 214 homes choosing to voluntarily submit quality improvement plans. In 2012-13, HQO also delivered the Residents First Leading Quality Annual Event.

As the initiative transitions by March 2014, the core concepts and assets (including improvement packages in falls reductions, emergency department utilization, pressure ulcer reductions, improving continence, and responsive behaviours) will be available to ensure the sector has the tools they need to retain a culture of quality improvement gained through the initiative.

Behavioural Supports Ontario

Behavioural Supports Ontario was a cross system project led by the 14 LHINs in partnership with stakeholders with the aim of enhancing services for older people with responsive behaviours linked to cognitive impairments, people at risk of cognitive impairments and their caregivers. Health Quality Ontario provided coaching training and mentoring to the 14 LHIN Improvement Facilitators, project leads and LHIN community partners. Health Quality Ontario's support included facilitating 14 value stream analyses[3] with 313 participants, 28 Kaizen events[4] with over 925 participants and 26.5 days of face-to-face training reaching over 650 participants.

Integrated Client Care Project – Palliative Care

The Integrated Client Care Project – Palliative Care was designed to improve the quality of care for palliative clients based in the community through integrated and evidence-based care delivery. Health Quality Ontario provided coaching, training and tools to five cross-sector palliative care delivery sites. Following the successful conclusion of HQO's involvement in June 2012, the Ontario Association of Community Care Access Centres incorporated the model into their regular business practices.

3 Value Stream Analysis is a methodology that can be used to understand the current state and patient needs. *Quality Improvement Science. Health Quality Ontario. Queen's Printer for Ontario (April 2013).*

4 Kaizen is Japanese for improvement and refers to philosophy or practices that focus upon continuous improvement of processes in business. Kaizen events are a tool to gather operators, managers and owners, map the existing process, improve on it and solicit buy-in from all parties. *Gemba Kaizen: A Commonsense, Low-Cost Approach to Management. Masaaki Imai. McGraw-Hill (March 1997).*

Public Reporting

As an independent agency, HQO is mandated to objectively monitor and publicly report to Ontarians on how well their health system is performing. Specifically, HQO must report on access to publicly funded health services, health human resources, consumer, and population health, and health system outcomes.

Quality Monitor

Each year, HQO produces Quality Monitor: A Report on Ontario's Health System, which analyzes whether quality has improved or worsened and where the province stands relative to Ontario benchmarks. Quality Monitor is widely distributed to health care organizations seeking ways to improve quality. The 2012 report includes measures of overall provincial level performance, comparisons by LHIN; measures for leading practice in the world as a benchmark for comparing performance within Ontario, Canada, and internationally; and run charts of performance at quarterly to yearly intervals. Summaries of LHIN-level data provide a sub-provincial review of the quality and performance within each of these 14 regional networks; and success stories and areas for improvement are included to inspire quality improvement work.

In 2012-13, HQO initiated consultations with key stakeholders on setting priorities for HQO's public reporting efforts. Key domains and indicators were identified as potential health system priorities such as chronic disease, population health, mental health and end-of-life care. In the coming year, HQO will adjust its approach to public reporting and Quality Monitor in part to reflect the outcome of this consultation, but mainly to maximize the opportunity to refine our public reporting efforts to better meet the needs of a varied audience and maximize the value we deliver to the public.

Public Reporting Online

To supplement this work, HQO has launched several web properties that report on different indicators relating to long-term care, home care, and patient safety (acute care). In 2012-13, HQO expanded its online reporting efforts to the

hospital sector to support the transition of the myhospitalcare.ca website from the Ontario Hospital Association to HQO. Health Quality Ontario's public reporting web pages provide health care stakeholders, and patients, residents and clients and their families and caregivers unbiased information on the quality of health services in the province.

Long-Term Care

With recognition that public reporting helps increase transparency and accountability in health care, in 2008, HQO began the work required to measure and report to the public on the quality of home care and long-term care services in Ontario. In March 2012, HQO successfully launched a redesigned section of its website specific to long-term care public reporting and in October 2012 expanded the content to include quality indicator results for the over 600 long-term care homes in Ontario. The site is the most comprehensive public reporting site on long-term care quality in the country.

In addition, HQO worked on an initiative to develop aspirational benchmarks for nine long-term care quality indicators. These benchmarks are among the first provincial long-term care benchmarks in Canada, and their release will better support quality improvement in the long-term care sector.

Home Care

Health Quality Ontario's home care public reporting web pages give health care providers, prospective and current home care clients and their families and friends unbiased information on the quality of home care services in Ontario, helping to increase transparency and accountability in the sector. In 2012-13, HQO reported on 11 quality indicators at the provincial and Community Care Access Centre-level. With the goal of creating the most comprehensive home care site in Canada, HQO is working towards reporting home care quality indicator results at the service provider-level.

Acute Care

In 2012-13, HQO assumed responsibility for posting patient safety (acute care) data previously reported on the ministry's website. In addition to the nine patient safety indicators already required, HQO is working to expand hospital reporting to include new system- and hospital-level indicators covering topics such as patient experience, readmission rates and alternate level of care.

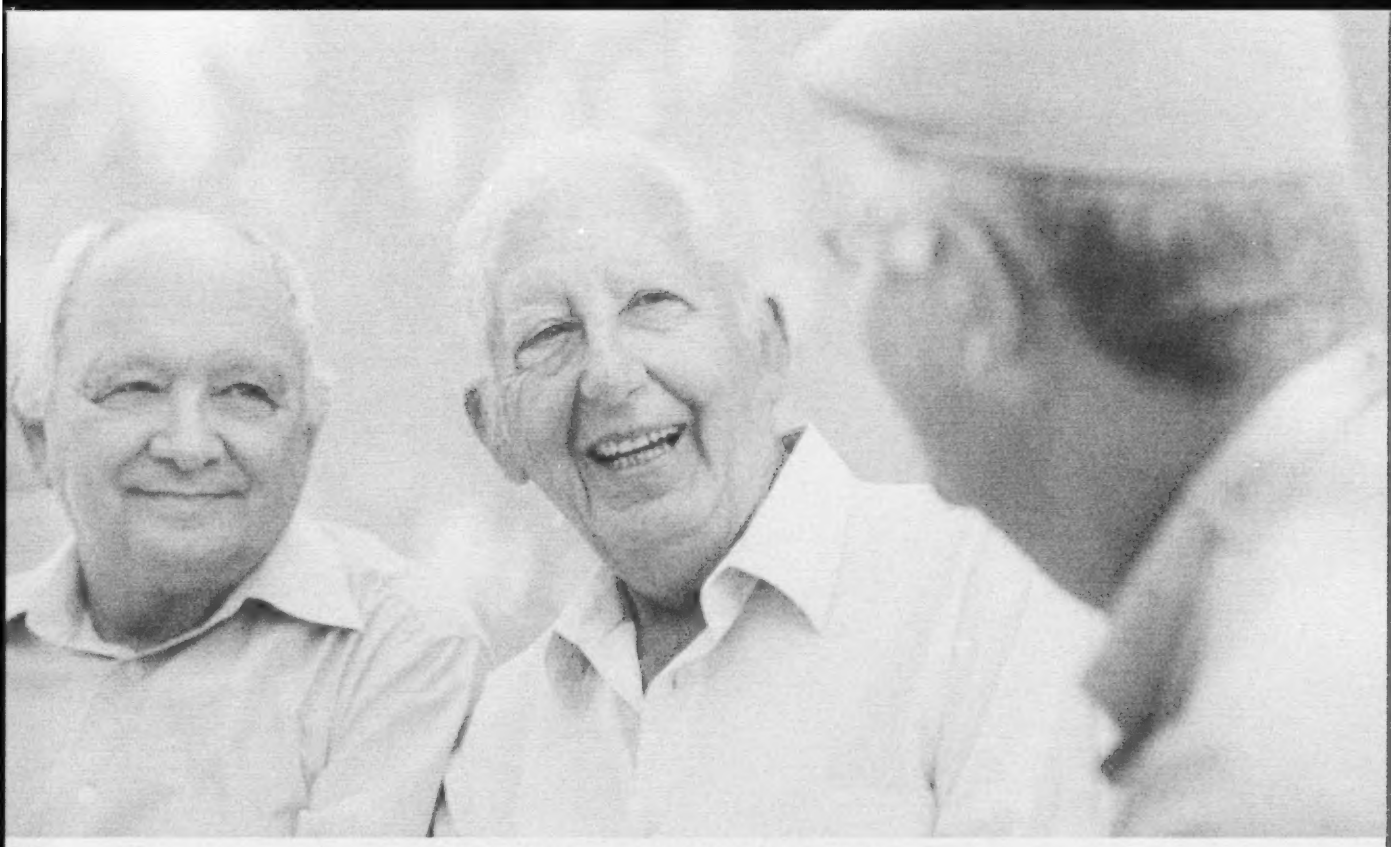
With the vision of integrated online content for all three sectors – home care, acute care and long-term care – in the future, HQO plans to create a central hub for its public reporting information with the goal of providing a public friendly site complemented with a greater level of detail and more easily accessible information for providers.

Primary Care Performance Measurement

In partnership with key stakeholders, HQO is developing a comprehensive performance measurement framework for primary care in Ontario to address the information needs of patients, the public, health care providers and policymakers. This initiative emerged in response to a proposal by the Primary Healthcare Planning Group to lay the groundwork for measurement activities related to quality improvement in primary care and support primary care QIP readiness.

In November 2012, HQO and the Canadian Institute for Health Information, in collaboration with their partners, held the Ontario Primary Care Performance Measurement Summit, an invitational meeting of senior leaders from key primary care data partners and information users in Ontario. As a result of the summit, preliminary primary care performance measurement priorities in Ontario were identified and participating organizations committed to engage in ongoing collaborative work on primary care performance measurement.

Now guided by the Ontario Primary Care Performance Measurement Steering Committee, HQO will take forward recommendations on primary care performance measurement priorities to inform a range of future primary care performance measurement activities.



Engaging our Partners

While it is important to identify practice standards for the health system, it is not on its own sufficient. Health Quality Ontario recognizes that it needs to work with a wide range of stakeholders to support adoption. To bridge the gap between evidence and practice requires active engagement between providers and researchers. Health Quality Ontario has undertaken work in the following key areas to develop the supports required to facilitate active ongoing engagement with our partners and stakeholders.

Health Quality Transformation

In 2012, HQO hosted Health Quality Transformation, a highly successful annual conference. The event brought together over 700 leaders, providers, researchers, government and other key stakeholders from across Ontario's health care system – primary care, acute care, long-term care, LHINs, and other HQO partner organizations – to work together towards a common quality agenda.

Health Quality Transformation is the evolution of an event historically co-led with the ministry and the Ontario Hospital Association. The 2012 event was the first year that HQO was solely responsible for executing the event, broadening the scope to include all sectors with a message of integration that reflects the work of our organization.

Partnerships

Partnerships are the fundamental building blocks of HQO's strategy and our mandate to support transformational improvements in Ontario's health care system. Proactive and well-developed relationship management capacity is required to leverage system partner expertise whenever possible, promote linkages across the system, and facilitate system integration. In the past year, HQO has developed and implemented a strategic partnership framework that outlines transparent, accountable, thoughtful, and strategically aligned processes to foster a culture that supports a partnership mindset.

Performance Measures and Financial Performance

Performance Measures

In order to drive quality improvement within HQO and maximize our impact on the health system, HQO developed a Performance Measurement Framework. This strategic and standardized approach to assessing the performance of our programs and initiatives continuously captures our progress.

Financial Performance

Building on the strategic plan of 2011-12, HQO reorganized itself in the spring of 2012 into five distinct branches; namely: Integrated Program Delivery, Evidence Development and Standards, Health System Performance, Strategic Partnerships and Communications, and Enterprise Strategy and Operations.

This reorganization was designed to support HQO's mandate, established by the *Excellent Care for All Act*, 2010, to monitor and report to the people of Ontario on the quality of their publicly funded health care system, to support continuous quality improvement in that system, and to promote health care that is supported by the best available scientific evidence. The reorganization enables HQO to remain committed to its strategic goals to focus the system on a common quality agenda; build evidence and knowledge; broker improvement; catalyze spread; and evaluate performance.

In this regard, HQO received base funding of $23.2 million to support its core activities as well as additional project funding in the amount of $9 million to support initiatives such as Appropriateness, bestPATH, Residents First, Behavioural Supports Ontario, Integrated Client Care-Palliative Care (ICCP), and Web. Most activities and projects demonstrated integration across HQO as they were supported by one or more branches.

As we continued to integrate and adapt to our new organizational structure, HQO did face some personnel challenges. Health Quality Ontario underwent a CEO transition part way through the year and consequently, deferred hiring some senior management positions. In addition, we experienced higher personnel turnover in the early part of the fiscal year than normal, which impacted program delivery to some degree and resulted in temporary vacancies over the course of the year.

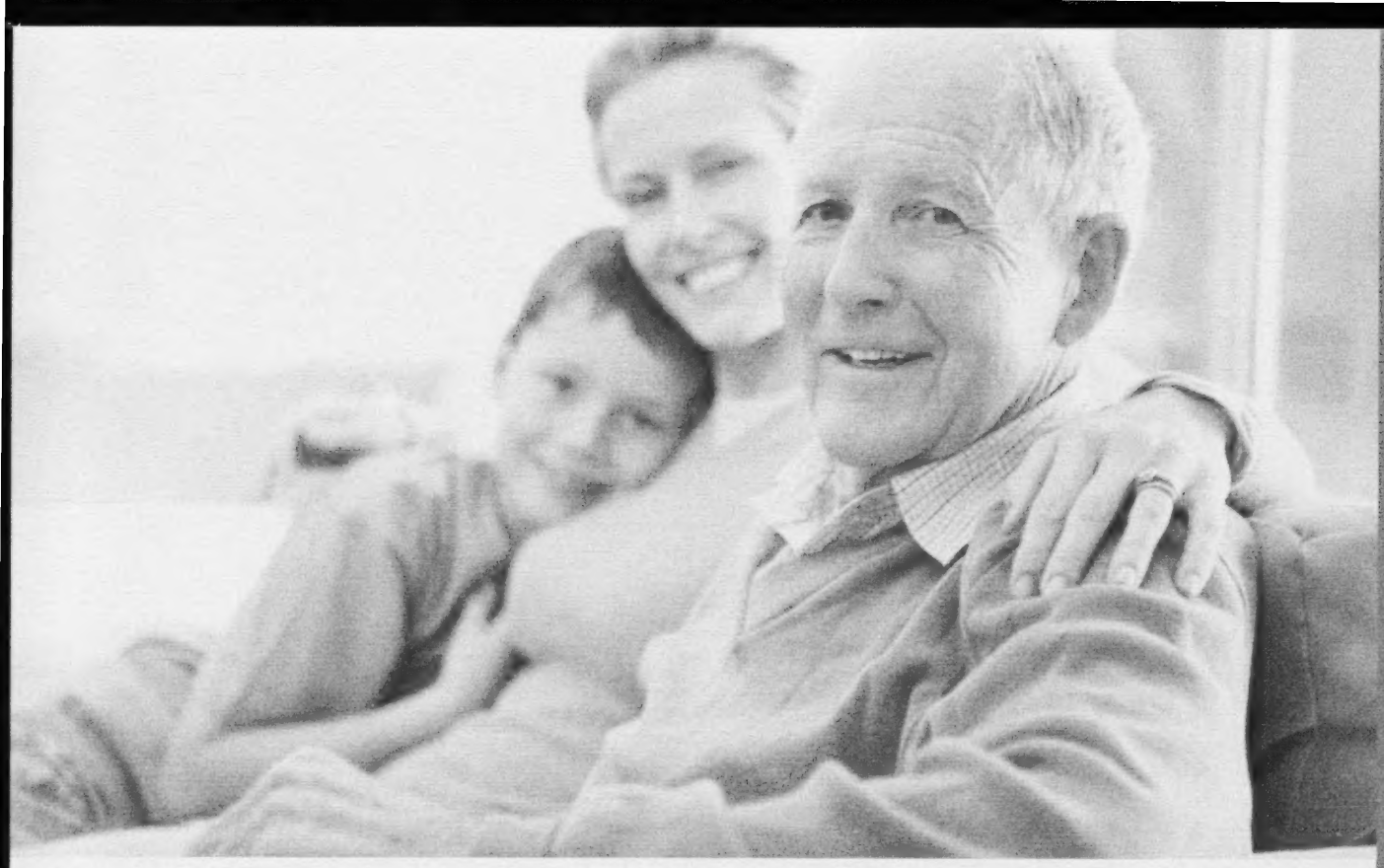
The aforementioned personnel issues in part contributed to HQO's surplus of $5.5 million against an approved budget of $32.2 million.

Health Quality Ontario's Health Quality Transformation (HQT) event, which brought together more than 700 stakeholders from across the system, including acute care, primary care, and long-term care providers, LHINs, and other HQO partner organizations to mobilize on key health system transformation topics, was delivered below forecast. In addition, some projects within our Health Technology Fund were deferred while others were transformed and a key initiative, bestPATH, went through several redesigns as HQO worked to align the project with the government's Action Plan for Health Care and the evolving Health Links initiative, all of which contributed nearly $2.3 million to the overall under-spend or 7% of the total budget and 42% of the resulting surplus.

Health Quality Ontario has consulted with health system stakeholders, and its funder the ministry, in order to sharpen its focus, leverage its partnerships and integrate its resources.

Looking ahead to 2013-14, we will complete the reorganization of HQO. Our internal alignment is complemented by our alignment with broader health system priorities, which will enable HQO to move forward rapidly, with a sharpened focus and strong partnerships to maximize its contribution to the transformation of health care in Ontario.

Detailed financial information can be found in the Audited Financial Statements at the end of this report.



Governance

Health Quality Ontario operates under the oversight of a board that consists of between nine and 12 members appointed by the Lieutenant Governor in Council, including the designated chair and vice-chair. The *Excellent Care for All Act*, 2010, specifies a skill mix to be considered. All members work for the board on a part-time basis.

Board membership for the 2012-13 fiscal year is listed below along with their terms:

Board Member	Term
Lyn McLeod (Chair)	August 18, 2005 – August 17, 2012
Marie E. Fortier (Vice Chair)*	May 4, 2011 – May 3, 2014
Richard Alvarez	January 4, 2011 – January 3, 2014
Tom Closson	August 15, 2012 – August 14, 2015
Faith Donald	January 27, 2010 – August 17, 2014
Bob Gardner	January 27, 2010 – January 26, 2013
Jeremy Grimshaw	August 18, 2011 – August 17, 2014
Andy Molino	April 16, 2008 – April 15, 2014
Gilbert S. Sharpe	March 3, 2010 – March 2, 2013
Tazim Virani	May 17, 2011 – May 16, 2014

*Marie E. Fortier served as Acting Chair in the 2012-13 fiscal year from August 18, 2012 onwards.

Conclusion

In the coming year, HQO will increase the reach of its efforts through strategic use of its resources, not more resources. As we look back on the past year, we have many accomplishments of which to be proud of. The strategic investments made in building our organization and fostering a culture of focus, integration and partnerships will have a lasting effect that will lay the groundwork for future success.

Health Quality Ontario is setting a direction for its future that aligns its work with both its strategic plan and major health system priorities. By focusing some of our future work on addressing patients with the greatest health care needs and supporting Health Links communities, HQO is positioned as a key partner supporting the province's health transformation agenda.

Health Quality Ontario is committed to focusing its efforts to maximize impact, while ensuring the knowledge and gains made by initiatives that are transitioning (such as Residents First) are harnessed by our new integrated program delivery model so that they can be used across the system. Tools and resources will be developed to further spread improvement and enable more providers to make more lasting change – and we will be changing the direction of how we report on the progress of health system to ensure our public reporting work meets the needs of the public.

Working together with our partners, our work can support improved care for Ontarians and a sustainable system that can deliver evidence-based care to future generations.

Compendium: Summary of 2012-13 Evidence-Based Recommendations

To meet requirements under HQO's Accountability Agreement with the ministry, below is a summary of all the evidence-based recommendations made to the ministry or health system during 2012-13. Complete details are available on our website.

Transcatheter Aortic Valve Implementation for the Treatment of Aortic Valve Stenosis	
Date	**May 2013**
Description	Narrowing of one of the heart valves (called aortic valve stenosis) makes it difficult for the heart to work properly. Often, patients have surgery to replace the narrowed valve, but surgery is too risky for some. In 2012, HQO published a systematic review and economic analysis on a less invasive treatment option called transcatheter aortic valve implantation (TAVI).
OHTAC Recommendations	In patients with severe aortic valve stenosis who are candidates for surgery, in light of the high complication rates of TAVI, and similar effectiveness and unfavourable cost-effectiveness compared with surgery, OHTAC does not recommend using TAVI. In patients with severe aortic valve stenosis who are not candidates for open-heart surgery, TAVI is a reasonable option. However, given the high complication rates and uncertainty regarding short- and long-term effectiveness and cost-effectiveness of TAVI, OHTAC recommends close follow-up of patient resource use, quality-of-life preference information, and clinical outcome data as a coverage with evidence development through Programs for Assessment of Technology in Health (PATH) and in collaboration with the Cardiac Care Network. A final decision regarding the use of this technology, including appropriate patient selection in Ontario, should be predicated on the outcomes from the coverage with evidence development. Given the complexity of this technology and significant complications associated with its use, OHTAC recommends in the interests of the highest quality of patient care that TAVI be restricted to institutions that have broad-based experience in its use with an appropriate volume of patients.
Implementation Status	Implemented by health system

24-Hour Ambulatory Blood Pressure Monitoring in Hypertension	
Date	**May 2012**
Description	Accurate blood pressure measurement can be challenging because blood pressure may vary naturally throughout the day, or an individual may exhibit "white-coat hypertension" where blood pressure is high at the doctor's office but normal in everyday life. 24-hour ambulatory blood pressure monitoring (ABTM) technology involves recording an individual's blood pressure every 15-30 minutes during usual activities over a 24-hour period. At the time the evidence-based review was conducted, this device was not insured in Ontario but was available in most large urban centres through some selected specialists and/or family physician groups. Health Quality Ontario conducted a systematic review of the evidence of the clinical effectiveness of this technology for managing hypertension and collaborated with its research partner - the Toronto Health Economics and Technology Assessment (THETA) Collaborative – to prepare an economic analysis.
OHTAC Recommendations	• Current use of conventional, clinic/office blood pressure monitoring should be optimal and in accordance with established guidelines. o For diagnosed patients in whom there is clinical suspicion for white-coat hypertension (i.e., ongoing discrepancy between in-clinic blood pressure and non-clinic measured blood pressure), 24-hour ABPM should be made available. o Adequate education, training, and quality assurance of the optimal use of the ABPM device is required for clinical and technical personnel, and for patients. To achieve this, the technology should be made available only in health care clinics with teams or facilities with expertise in hypertension.
Implementation Status	Recommendation submitted to the ministry for consideration

Multiple Intravenous Infusions Phase 1B: Practice and Training Scan Instead of Investigating Safety Issues Related to Multiple Intravenous Infusions	
Date	**May 2012**
Description	Health Quality Ontario commissioned HumanEra (formerly the Health Technology Safety Research Team) at the University Health Network to conduct a multi-phase study to identify and mitigate the risks associated with multiple intravenous (IV) infusions. Some of the questions addressed by the team were: What is needed to reduce errors for individuals who are receiving a lot of medications? What strategies work best? HumanEra worked in close collaboration with the Institute for Safe Medication Practices Canada on an exploratory study to understand multiple IV infusion risks and the degree to which nurses are educated to help mitigate them. Their report presents the findings of a field study of 12 hospital clinical units across Ontario, as well as 13 interviews with educators from baccalaureate-level nursing degree programs and postgraduate Critical Care Nursing Certificate programs. It includes recommendations that emphasize best practices for the administration of multiple IV infusions. As part of Phase 1b, HumanEra produced an associated report for hospitals: Mitigating the Risks Associated with Multiple IV Infusions: Recommendations Based on a Field Study of Twelve Ontario Hospitals, highlighting the nine interim recommendations and providing a brief rationale for each one.

Multiple Intravenous Infusions Phase 1B: Practice and Training Scan Instead of Investigating Safety Issues Related to Multiple Intravenous Infusions	
OHTAC Recommendations	**Secondary Infusions** 1. When initiating a secondary medication infusion (often referred to as a piggyback infusion), nurses should verify that the secondary infusion is active—and that the primary infusion is not active — by viewing the activity in both drip chambers. Full drip chambers should be partially emptied to restore visibility. 2. Continuous high-alert medications should be administered as primary infusions. Continuous high-alert medications should not be administered as secondary infusions. No secondary medications should be connected to high-alert primary continuous infusions. 3. Secondary infusions should be attached to primary infusion sets that have a back check valve. If infusion sets without back check valves are also available, multiple strategies should be employed to ensure that the types of tubing available are easily differentiated, and that the likelihood of a mix-up is minimized. **Line Identification** 4. Hospitals should work towards the use of gowns that have snaps, ties, or Velcro on the shoulders and sleeves to facilitate line tracing and gown changes. Metal fasteners (e.g., metal snaps) should be avoided to prevent patient burns if a gown with metal fasteners goes into the magnet room of an MRI suite. 5. If an "emergency medication line" controlled by an infusion pump is set up, it is strongly suggested that the associated primary IV tubing be labelled as the emergency medication line at the injection port closest to the patient. The label should be prominent and visually distinct from all other labels in the environment. **Line Set-Up and Removal** 6. When setting up multiple IV infusions at the same time (e.g., a new patient requires many ordered infusions immediately, routine line changes), infusions should be set up 1 at a time, as completely as possible, before setting up the next infusion. Set-up tasks required for each infusion vary and may include: o Labelling (e.g., IV tubing, pump) o Spiking and hanging the IV bag o Connecting the IV tubing to the pump o Programming the IV pump o Connecting the IV tubing to the appropriate location (e.g., patient access, manifold) o Starting the pump (unless a secondary infusion must be set up prior to starting the pump, or other infusions need to be connected to a multi-port connector before flushing) 7. Multiple 3-way stopcocks joined together in series to connect multiple IV infusions into a single line are prone to leaks, which may often be undetectable. Hospitals should provide multi-port or multi-lead connectors, and nurses should use these connectors to join multiple IV infusions into a single line, as required.

Multiple Intravenous Infusions Phase 1B: Practice and Training Scan Instead of Investigating Safety Issues Related to Multiple Intravenous Infusions	
	IV Bolus Administration 8. Hospitals should develop a policy to limit the practice of manually increasing the infusion rate to administer a medication bolus of a primary continuous infusion. If a separate medication bolus cannot be prepared, and the bolus is administered using the primary continuous infusion pump/pump channel, then the nurse should program the bolus dose parameters (i.e., total amount of medication to be given over a defined duration) into the pump without changing any of the primary infusion parameters. Some examples of how to specify the bolus dose parameters include the following: o Programming a bolus using a dedicated bolus feature in the pump (preferred, if available) o Programming a bolus using the pump's secondary feature but without connecting a secondary IV bag (pump will draw the bolus from the primary IV bag) 9. Hospitals should ensure that their smart pump drug libraries include hard upper limits for as many high-alert medications as are appropriate for each clinical area, in order to prevent the administration of a bolus by manually increasing the primary flow rate.
Implementation Status	Recommendations made on evidence-based review are currently being evaluated in the field

Epilepsy Surgery: An Evidence Summary	
Date	**July 2012**
Description	About 30% of people in Ontario with epilepsy continue to have seizures despite optimal drug treatment. In some of these patients surgery is potentially an option to attempt to control the number of seizures. Patients are carefully selected for surgery based on their frequency of seizures, location of seizure in the brain and type of seizures. There is good evidence to indicate that surgery is an effective and safe option for some patients with drug-refractory epilepsy. Following an initial evidence-based analysis by the former Medical Advisory Secretariat and an OHTAC recommendation, the Programs for Assessment of Technology in Health (PATH) Research Institute conducted a field evaluation in collaboration with the Centre for Brain Behaviour at the Hospital for Sick Children in Toronto. The field evaluation explored the barriers to accessing epilepsy surgery in the province and reported the results to OHTAC in January 2011. Based on the findings of the field evaluation, OHTAC requested the creation of a Provincial Epilepsy Strategy Working Group to provide additional centre-specific data and a front-line perspective. The working group report was presented to OHTAC in March 2011, which spurred the creation of an OHTAC Expert Panel on a Provincial Strategy for Epilepsy Care in Ontario. The panel provided a report on the current state of care for refractory epilepsy in Ontario and developed recommendations for a provincial strategy for epilepsy care. OHTAC recommended that the report of the Expert Panel be used as a resource in developing a provincial approach to addressing epilepsy care. As part of its consultation process with public and professional stakeholders in the fall, OHTAC posted its draft recommendation for epilepsy care along with the related research and reports. The consultation generated an overwhelmingly positive response from professionals, advocacy groups and members of the public. Health Quality Ontario's Board requested further research to analyse the cost of implementing the strategy. The evidence is convincing that epilepsy surgery for drug-refractory epilepsy for adults and children is highly effective at eliminating or reducing the frequency of seizures. Furthermore, epilepsy surgery is cost-effective, and the cost-effectiveness improves over the long term and would be even more favourable if the analysis was done from a societal perspective that considers indirect costs, lost productivity, caregiver burden, etc. Evidence also demonstrates that an integrated epilepsy program that provides both medical and surgical management is also cost-effective in the long term. Despite this evidence, less than 2% of patients who might benefit from epilepsy surgery do so because of the lack of a systematic approach to this problem.
OHTAC Recommendations	OHTAC recommends that the report of the Expert Panel on a Provincial Strategy for Epilepsy Care on improving access to the necessary diagnostic testing for surgical candidacy for epilepsy surgery be used as a resource in developing a provincial approach to addressing this issue. OHTAC further endorses the accompanying economic analysis on costing and the high-level implementation plan from the report.
Implementation Status	Recommendation submitted to the ministry for consideration

Metal-on-metal Hip Resurfacing Arthroplasty: An Analysis of Safety and Revision Rates	
Date	**August 2012**
Description	Total hip replacement has long been considered the treatment of choice for advanced osteoarthritis of the hip in older patients. For younger and more active people, however, some surgeons favour metal on metal hip resurfacing arthroplasty (HRA) as an alternative to total hip replacement. The aim of the HRA procedure is to preserve the proximal femoral bone and to restore the normal anatomy and biomechanics of the joint. This will help to "buy time" until the individual is older and conventional hip replacement would be more appropriate. It is perceived that HRA is better suited to the active lifestyle of younger people who place additional stress on their prostheses, for a longer period of time. While surgeons may discourage running and high-impact activities following a hip replacement, some studies show that patients undergoing hip resurfacing are able to participate in high-impact activities with minimal negative consequences and appear to have greater range of motion. However, a potential concern is the fact that metal on metal hip resurfacing implants are made of cobalt-chromium alloy and a body of literature has shown a rise in the concentration of cobalt and chromium in the blood and urine of patients following resurfacing arthroplasty. The worldwide withdrawal of one of the hip resurfacing implants due to higher than expected revision rates resulted in some uncertainty regarding the revision rates of other implants. Surgeons in favor of the technique believe that the clinical history of one device cannot be extrapolated to other devices and therefore, continue to perform this procedure with careful patient selection to prevent complications and to optimize durability. Health Quality Ontario conducted an evidence-based analysis to compare the revision rates for HRA implants with the benchmark set by the National Institute of Clinical Excellence (NICE). The potential safety issues due to exposure to high levels of metal ions were also reviewed.
OHTAC Recommendations	Metal-on-metal HRA is a reasonable treatment option for osteoarthritis patients who meet the appropriate criteria. • Metal-on-metal HRA should only be performed by surgeons who have appropriate training and who have acquired a high level of experience by performing a high annual volume of THAs and MOM HRAs. • There is evidence of increased cobalt and chromium levels in the blood and urine of patients who receive MOM HRA; however, there is no conclusive evidence that exposure to high metal ion levels has harmful biological consequences. As such, OHTAC recommends that patients receiving these implants be informed of the potential for exposure to metal ions, and that the adverse effects and long-term implications of elevated metal ion exposure in patients who receive these implants are not known at this time. • Since cobalt and chromium can pass the placental barrier, OHTAC recommends that non-MOM bearing surfaces be used in women of childbearing ages who require hip arthroplasty.
Implementation Status	Implemented by health system

Specialized Community-Based Care	
Date	**November 2012**
Description	Specialized community-based care, often referred to as intermediate care, is care provided to people with chronic illnesses who need more than basic care, but do not require intensive care. There is convincing evidence that this type of care, which is provided through formal links between primary and specialized care, improves outcomes in patients with heart failure, chronic obstructive pulmonary disease (COPD) and diabetes. Health Quality Ontario is conducting a series of evidence-based analyses of specialized community-based care to: • Review the literature on intermediate care for chronic diseases • Synthesize the evidence from four previous analyses of specialized community-based care for COPD, heart failure, diabetes, and chronic wounds • Examine the role of intermediate care within family practice. In addition to the evidence-based analysis, the Toronto Health Economics and Technology Assessment (THETA) Collaborative conducted a field evaluation that identified heart failure clinics in Ontario and analyzed services using hospitalization and mortality rates. Based on the evidence, HQO worked with the Cardiac Care Network to develop standards of care for heart failure clinics. The November 2012 report, which focused on heart failure, provided the evidence for the first of four sets of recommendations that will come out of this research.
OHTAC Recommendations	Based on moderate-to-high quality evidence of improved patient and health system outcomes through specialized community-based care (intermediate care), OHTAC recommends the following: • Access to specialized community-based care (intermediate care) should be made available for patients with chronic diseases, and whose diseases are becoming uncontrollable despite primary care. • Recognizing that primary care is the optimal way of treating and coordinating the care of patients with co-morbidities, patients should be returned to primary care for further follow-up with the revised treatment plan once they have been stabilized through intermediate care access. • Recognizing the complexities of these recommendations, HQO should develop a high-level implementation plan that would provide advice regarding the adoption of these recommendations. • In addition, Local Health Integration Networks should be approached to seek their interest in implementing OHTAC intermediate care recommendations in collaboration with experts. • Evidence-based standards for multidisciplinary community-based care derived from EBAs, economic analyses, and field evaluation studies, as appropriate, should be derived for each of the chronic diseases. • Heallth Quality Ontario should consider developing quality performance indicators based on these standards of care, tracking adherence to these standards and using this evidence base for developing quality-based funding.

Specialized Community-Based Care	
OHTAC Recommendations	Based on evidence of effectiveness, economic analysis, and a field evaluation study, OHTAC makes the following recommendations relating to standards of care for specialized multidisciplinary heart failure clinics. These standards were endorsed by a CCN expert working group. Further standards of care will be considered by OHTAC for diabetes and wound care once the results from field evaluation studies (currently underway) become available, and for COPD once the expert review panel has reviewed the evidence and formatted standards for OHTAC's consideration.
	Evidence-Based Components 1. Active medication titration to evidence-based target doses should be a key priority of heart failure clinics. • The expert panel agreed that the beneficial effect of appropriate titration of medications on patient outcomes and hospitalization rates observed in the HQO and THETA analyses were likely a reflection of the use of the evidence-based medications in those clinics. • Targets for medication titration should be consistent with best evidence so that patients are treated with evidence-based heart failure medications and reach evidence-based target doses of medications. • Clinics should develop processes that support flexible and responsive medication-titration services, including multidisciplinary personnel and delegated medical acts where appropriate. 2. Care should be consistent with evidence-based guidelines for the management of heart failure. • See recommendation 1, above. 3. Health care professionals should provide education, self-management training, and counselling to patients and their informal caregivers. Special efforts should be made to encourage informal caregivers to participate in patient management to ensure knowledge translation has been successful whenever possible. 4. Mechanisms that enable appropriately frequent follow-up should be built into the model of heart failure clinics. • Achieving optimal community-based medication titration will depend on a health care delivery model that can accommodate frequent patient follow-up, tailored to the patient's risk and clinical status, especially for patients whose disease is not fully stabilized (such as patients who have been recently discharged from hospital).
	Expert Opinion-Based Components 5. Mechanisms that enable rapid access (within 1–3 days) to specialized care should be built into the model of heart failure clinics. • Hospitals are currently serving as the rapid access points for the deteriorating patient. • A capacity for preferably community-based rapid intervention should be developed. Many patients who experience deterioration in their clinical status often require only a transient period of stepped-up care in an observation unit where they can be diuresed and monitored. Because of the lack of availability of these types of services, patients do not have options other than the emergency department in these cases.

Specialized Community-Based Care	
OHTAC Recommendations	6. A structure of the roles and responsibilities, collaboration, and communication between heart failure specialists, primary care providers, and hospital inpatient physicians should be developed and implemented to facilitate efficient and effective seamless care. • Heart failure clinics should be positioned to care for patients with advanced disease. Primary care clinics are well positioned to provide care to the greater majority of patients with more stable chronic heart failure. • Heart failure clinics and primary care clinics can take on complementary roles and should collaborate in a more focused way. This would involve ensuring that primary care providers understand how to interact, communicate, and consult with heart failure specialist teams in the management of individual patient cases. • Because heart failure patients commonly have multiple coexisting illnesses and often complex social circumstances, primary care plays a critical role in delivering patient-centred care for these patients. Therefore, integration and coordination of specialty and primary care is essential. • Formal structure and mechanisms should be developed to facilitate efficient and effective seamless care between in-hospital care management and heart failure specialists, and primary care providers and home-care providers. There should be patient discharge letters that provide explicit medication titration parameters as guidance for primary care providers. A heart failure action plan is essential for the successful management of these patients. • These considerations should guide how specialists and primary care providers should interact, in a manner consistent with the Chronic Disease Model. While there clearly is a need for specialists to provide direct consultation services, particularly for the most complex patients, there is also a need for specialists to be involved in capacity building. This may take place in the form of formal or informal case reviews, or by having the specialists and primary care clinicians seeing patients together. The traditional formal silo between the primary care clinician and the specialist needs to be broken down, as even the best and most timely consult letter will not convey what is needed for the primary care clinicians to become comfortable managing heart failure. An important consequence of breaking down this silo will be the development of a greater understanding of the needs of primary care by the specialist, as well as the building of trust. A further consequence is that a formal and close working relationship between the specialist and primary care can act as a knowledge transfer and exchange conduit for disseminating the results of new clinical trials or guideline recommendations. • Before the program is launched, appropriate standards and training should be more clearly defined to ensure delivery of quality care by providers with adequate competency and experience. • An important consideration in the design of linkages between specialists and primary care is the type of training the primary care practitioners in heart failure care receive. Most of the exposure of primary care trainees to heart failure specialists occurs on inpatient acute care units. Few primary care practitioners receive training from heart failure specialists on the outpatient management of chronic heart failure. Most of their learning comes from continuing medical education events or other family medicine residency preceptors or colleagues. As a result, primary care practitioners lack confidence in their cardiovascular clinical skills or may not be comfortable managing complex patients with vital sign abnormalities that a heart failure specialist may regard as normal. In addition, primary care clinicians may be unfamiliar with techniques that specialists routinely use to titrate medication doses (e.g., reducing nitrates or diuretics in order to have "blood pressure room" to increase the dose of angiotensin-converting-enzyme inhibitors).

Specialized Community-Based Care	
OHTAC Recommendations	7. Once patients are stabilized, heart failure clinics need to demonstrate that they are referred back to primary care with a care management plan. 8. Health Quality Ontario will work with experts, CCN, and heart failure clinics to develop and promulgate standards to be followed by heart failure clinics and their referral base throughout the Local Health Integration Networks.
Implementation Status	Implemented by health system

Midurethral Slings for Women with Stress Urinary Incontinence	
Date	**January 2013**
Description	Stress urinary incontinence is characterized by involuntary leakage of urine on coughing, sneezing, laughing or exercise. If lifestyle changes, such as pelvic floor exercises and elimination of caffeine intake are unsuccessful, invasive (colposuspension) and noninvasive (midurethral slings) surgical options are available. In 2006 and 2009, new Canadian Classification of Health Interventions codes were introduced for midurethral sling insertions, management and removal, to allow for better tracking of the use of this intervention and complication rates. In 2008, a fee code for midurethral slings was added to the Ontario Schedule of Benefits. In 2013, OHTAC updated its recommendations on midurethral slings in response to concerns regarding the safety of the device.
OHTAC Recommendations	Original 2006 OHTAC Recommendation Explore the introduction of unique Canadian Classification of Health Interventions (CCI) codes so that midurethral slings can be tracked according to retropubic and transobturator routes through administrative databases—to assess, in particular, variation in complication rates (Note: new CCI codes were added in 2006 to track management and removal of the midurethral slings). Updated 2013 OHTAC Recommendation Please note the Notice to Hospitals from Health Canada (http://www.hc-sc.gc.ca/dhpmps/medeff/advisories-avis/prof/_2010/surgical-mesh_nth-aah-eng.php) that highlights the need for physicians to: 1) review warnings on devices; 2) inform patients of adverse events; 3) watch for signs of intraoperative and postoperative complications; and 4) maintain training for procedure and management of complications.
Implementation Status	Recommendation submitted to the ministry for consideration

ONTARIO HEALTH QUALITY COUNCIL
o/a HEALTH QUALITY ONTARIO

FINANCIAL STATEMENTS
March 31, 2013

Table of Contents

INDEPENDENT AUDITORS' REPORT 35

STATEMENT OF FINANCIAL POSITION 37

STATEMENT OF OPERATIONS 38

SCHEDULE 1 – ENTERPRISE STRATEGY AND OPERATIONS 39

SCHEDULE 2 – INTEGRATED PROGRAM DELIVERY 40

SCHEDULE 3 – STRATEGIC PARTNERSHIP AND COMMUNICATIONS 41

SCHEDULE 4 – HEALTH SYSTEM PERFORMANCE 42

SCHEDULE 5 – EVIDENCE DEVELOPMENT AND STANDARDS 43

SCHEDULE 6 – TRANSITION EXPENSES 44

STATEMENT OF CASH FLOWS 45

NOTES TO THE FINANCIAL STATEMENTS 46

SCHEDULE OF OPERATIONS COMPARED TO BUDGET 50

LOFTUS ALLEN & CO. PROFESSIONAL CORPORATION
CHARTERED ACCOUNTANTS

INDEPENDENT AUDITORS' REPORT

To The Board of Ontario Health Quality Council o/a Health Quality Ontario:

We have audited the accompanying financial statements of Ontario Health Quality Council o/a Health Quality Ontario, which comprise the statement of financial position as at March 31, 2013, and the statements of operations, and cash flows for the year then ended, along with a summary of significant accounting policies, related schedules, and other explanatory information. The financial statements have been prepared by management based on the financial reporting provisions established by the Ministry of Health and Long-Term Care and the Canadian Public Sector Accounting Standards.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation of these financial statements in accordance with Canadian Public Sector Accounting Standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal controls relevant to the entity's preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Suite 107, 5409 Eglinton Avenue West
Toronto, Ontario M9C 5K6

LOFTUS ALLEN & CO. PROFESSIONAL CORPORATION
CHARTERED ACCOUNTANTS

INDEPENDENT AUDITORS' REPORT *continued*

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Ontario Health Quality Council o/a Health Quality Ontario as at March 31, 2013 and the results of its operations and its cash flows for the year then ended in accordance with the Canadian Public Sector Accounting Standards.

Basis of Accounting and Restriction of Use

Without modifying our opinion, we draw attention to Note 2 of the financial statements which describes the basis of accounting. The financial statements are prepared to assist the Ontario Health Quality Council o/a Health Quality Ontario to meet the requirements of their funding agreement with the Ministry of Health and Long-Term Care. As a result, the financial statements may not be suitable for another purpose. Our report is intended solely for Ontario Health Quality Council o/a Health Quality Ontario and the Ministry of Health and Long-Term Care and should not be used by other parties.

Loftus Allen & Co
Professional Corporation

Toronto, Ontario
June 20, 2013

Chartered Accountants, authorized to practice public accounting by
The Institute of Chartered Accountants of Ontario

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31, 2013
(with comparative figures for 2012)

	2013	2012
FINANCIAL ASSETS		
Cash	**$ 10,943,996**	$ 5,174,574
Cash for severance, *note 7*	**87,542**	86,668
Cash for vacation credits, *note 7*	**11,182**	11,070
	11,042,720	5,272,312
LIABILITIES		
Accounts payable and accrued liabilities	**2,118,228**	1,871,290
Severance funding liability, *note 7*	**87,542**	86,668
Vacation credits liability, *note 7*	**11,182**	11,070
Due to the Ministry of Health & Long-Term Care, *note 3*	**8,825,768**	3,303,284
	11,042,720	5,272,312
NON FINANCIAL ASSETS		
TANGIBLE CAPITAL ASSETS		
Computer and equipment	**315,295**	190,839
Office furniture and fixtures	**903,823**	903,823
Leasehold improvements	**1,227,930**	1,149,341
	2,447,048	2,244,003
Less: Accumulated amortization	**2,447,048**	2,244,003
	-	-
ACCUMULATED SURPLUS	$ -	$ -

APPROVED ON BEHALF OF THE BOARD:

Director

Director

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

STATEMENT OF OPERATIONS
FOR THE YEAR ENDED MARCH 31, 2013
(with comparative figures for 2012)

	2013	2012
REVENUE		
Ministry of Health and Long-Term Care	**$ 32,205,400**	$ 30,460,125
EXPENSES		
Enterprise Strategy and Operations* – Schedule 1	**6,380,660**	4,608,546
Integrated Program Delivery** – Schedule 2	**7,201,190**	9,985,445
Strategic Partnership and Communications – Schedule 3	**3,110,644**	1,083,789
Health System Performance – Schedule 4	**2,856,012**	2,110,424
Evidence Development & Standards – Schedule 5	**7,227,349**	7,023,363
Transition Costs – Schedule 6	-	2,419,542
	26,775,855	27,231,109
EXCESS OF REVENUE OVER EXPENSES	**5,429,545**	3,229,016
INTEREST INCOME	**102,892**	55,876
OTHER INCOME	-	8,439
DUE TO THE MINISTRY OF HEALTH AND LONG-TERM CARE, *note 3*	**$ 5,532,437**	**$ 3,293,331**

*** Enterprise Strategy and Operations:**
This branch encompasses the corporate governance function of HQO through the Office of the CEO and COO, provides the operational support such as Human Resources, Finance, IT and Organizational Development and drives the development and implementation of HQO's Strategic Plan, Business Plan, and Accountability Agreement through the Project Management Office.

**** Integrated Program Delivery:**
This Branch within HQO hosts a number of integrated and aligned quality improvement and capacity building programs, employing capabilities, tools and a knowledge base for high impact program design and execution to drive system level change. Expert resources are deployed in support of programs such as bestPATH, Advanced Access and Chronic Disease Management, Residents First, Behavioural Supports Ontario and Integrated Client Care Project – Palliative Care.

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

SCHEDULE 1 – ENTERPRISE STRATEGY AND OPERATIONS
FOR THE YEAR ENDED MARCH 31, 2013
(with comparative figures for 2012)

	2013	2012
BASE EXPENSES		
Salaries, Wages and Benefits		
Salaries and wages management	**$ 1,635,663**	$ 606,967
Salaries and wages non-management	**763,984**	339,309
Benefits	**431,098**	490,419
	2,830,745	1,436,695
Other Operating Expenses		
Leases	**947,980**	815,326
Finance/payroll services	**877,991**	238,337
IT Support and telecom	**856,119**	690,739
Consulting, research and communications	**60,607**	576,405
Events and travel	**137,360**	262,556
Supplies and equipment	**450,778**	588,488
	3,330,835	3,171,851
	6,161,580	4,608,546
ONE TIME PROJECTS - *Note 8*		
bestPATH (Person-centred, Appropriate, Timely Health Care)		
Salaries, wages and benefits	**205,484**	-
Behavioural Supports Ontario (BSO)		
Salaries, wages and benefits	**8,108**	-
Integrated Client Care Project (ICCP)		
Salaries, wages and benefits	**5,488**	-
	219,080	-
	$ 6,380,660	$ 4,608,546

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

SCHEDULE 2 – INTEGRATED PROGRAM DELIVERY
FOR THE YEAR ENDED MARCH 31, 2013
(with comparative figures for 2012)

	2013	2012
BASE EXPENSES		
Salaries, Wages and Benefits		
Salaries and wages management	$ 284,114	$ 471,524
Salaries and wages non-management	2,224,310	1,766,664
Benefits	572,148	401,941
	3,080,572	2,640,129
Other Operating Expenses		
Consulting, research and communications	340,265	260,312
Events and travel	277,893	684,783
	618,158	945,095
	3,698,730	3,585,224
ONE TIME PROJECTS - *Note 8*		
bestPATH (Person-centred, Appropriate, Timely Health Care)		
Salaries, wages and benefits	1,519,602	352,803
Payments to organizations	90,000	125,000
Consulting, research and communication	231,958	1,021
Events, travel and staff development	49,942	13,916
	1,891,502	492,740
Residents First		
Salaries, wages and benefits	959,627	3,785,590
Payments to organizations	-	212,500
Consulting, research and communication	49,131	129,332
Events, travel and staff development	262,493	463,055
	1,271,251	4,590,477
Behavioural Supports Ontario (BSO)		
Salaries, wages and benefits	171,032	304,406
Consulting, research and communication	5,535	-
Events, travel and staff development	22,918	16,995
	199,485	321,401
Integrated Client Care Project (ICCP)		
Salaries, wages and benefits	132,519	969,425
Consulting, research and communication	1,164	9,023
Events, travel and staff development	6,539	17,155
	140,222	995,603
	3,502,460	6,400,221
	$ 7,201,190	$ 9,985,445

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

SCHEDULE 3 – STRATEGIC PARTNERSHIP AND COMMUNICATIONS
FOR THE YEAR ENDED MARCH 31, 2013
(with comparative figures for 2012)

	2013	2012
BASE EXPENSES		
Salaries, Wages and Benefits		
Salaries and wages management	$ 333,965	$ 334,273
Salaries and wages non-management	642,520	349,552
Benefits	221,156	133,655
	1,197,641	817,480
Other Operating Expenses		
Consulting, research and communications	582,931	101,045
Events and travel	9,988	14,899
	592,919	115,944
	1,790,560	933,424
ONE TIME PROJECTS - *Note 8*		
bestPATH (Person-centred, Appropriate, Timely Health Care)		
Salaries, wages and benefits	33,725	-
Residents First		
Salaries, wages and benefits	5,987	-
Web Projects		
Salaries, wages and benefits	598,115	127,797
Consulting, research and communication	681,104	22,568
Events, travel and staff development	1,153	-
	1,280,372	150,365
	1,320,084	150,365
	$ 3,110,644	$ 1,083,789

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

SCHEDULE 4 – HEALTH SYSTEM PERFORMANCE
FOR THE YEAR ENDED MARCH 31, 2013
(with comparative figures for 2012)

	2013	2012
BASE EXPENSES		
Salaries, Wages and Benefits		
Salaries and wages management	**$ 272,799**	$ 315,052
Salaries and wages non-management	**1,139,512**	948,264
Benefits	**260,404**	223,012
	1,672,715	1,486,328
Other Operating Expenses		
Consulting, research and communications	**902,875**	586,360
Events and travel	**30,161**	37,736
	933,036	624,096
	2,605,751	2,110,424
ONE TIME PROJECTS - *Note 8*		
bestPATH (Person-Centred, Appropriate, Timely Health Care)		
Salaries, wages and benefits	**121,457**	-
Residents First		
Salaries, wages and benefits	**128,804**	-
	250,261	-
	$ 2,856,012	$ 2,110,424

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

SCHEDULE 5 – EVIDENCE DEVELOPMENT AND STANDARDS
FOR THE YEAR ENDED MARCH 31, 2013
(with comparative figures for 2012)

	2013	2012
BASE EXPENSES		
Salaries, Wages and Benefits		
Salaries and wages management	$ 394,052	$ 453,964
Salaries and wages non-management	1,295,549	1,436,746
Benefits	286,824	333,788
	1,976,425	2,224,498
Other Operating Expenses		
Consulting, research and communications	43,251	71,557
Events and travel	44,547	32,559
Payments to organizations	4,083,391	4,602,120
	4,171,189	4,706,236
	6,147,614	6,930,734
ONE TIME PROJECTS - *Note 8*		
Appropriateness		
Salaries, wages and benefits	646,422	-
bestPATH (Person-centred, Appropriate, Timely Health Care)		
Salaries, wages and benefits	433,313	92,629
	1,079,735	92,629
	$ 7,227,349	$ 7,023,363

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

SCHEDULE 6 TRANSITION EXPENSES
FOR THE YEAR ENDED MARCH 31, 2013
(with comparative figures for 2012)

		2013	2012
Office equipment and maintenance	$	-	$ 1,357,195
Professional fees		-	583,476
Lease		-	296,695
IT Professional services		-	154,996
Legal		-	27,180
	$	-	$ 2,419,542

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED MARCH 31, 2013
(with comparative figures for 2012)

	2013	2012
OPERATING TRANSACTIONS		
Cash received from:		
Ministry of Health and Long-Term Care	$ **32,205,400**	$ 30,901,125
Interest	**102,892**	55,876
Speaking engagements	-	8,439
	32,308,292	30,965,440
Cash paid for:		
Enterprise Strategy and Operations	(6,209,607)	(4,314,015)
Integrated Program Delivery	(7,133,946)	(9,675,460)
Strategic Partnership and Communications	(3,043,400)	(773,803)
Health System Performance	(2,788,768)	(1,800,438)
Evidence Development and Standards	(7,160,104)	(6,713,377)
Transition costs	-	(1,062,347)
	(26,335,825)	(24,339,440)
Cash provided by (applied to) operating activities	5,972,467	6,626,000
CAPITAL TRANSACTIONS		
Cash used to acquire tangible capital assets	(203,045)	(1,684,087)
Cash provided by (applied to) capital transactions	(203,045)	(1,684,087)
INCREASE IN CASH	5,769,422	4,941,913
CASH, beginning of year	5,174,574	232,661
CASH, end of year	$ 10,943,996	$ 5,174,574

The attached notes are an integral part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS MARCH 31, 2013

1. THE ORGANIZATION

The Ontario Health Quality Council is an independent agency, created under Ontario's *Commitment to the Future of Medicare Act* on September 12, 2005.

The Council was granted the business name Health Quality Ontario (HQO) on February 15, 2011. This merged organization coordinates, consolidates and strengthens the use of evidence based practice initiatives and technologies, supports continuous quality improvement and continues to monitor and publicly report on health system outcomes. HQO's mandate includes the recommendation of evidence informed care, providing continuous support for the adoption of standards of care among health care providers, and monitoring and reporting on Ontario's health system performance. The consolidation of the health quality infrastructure will increase accountability, build synergies amongst existing programs and allow the agency to focus on the patient's entire care journey across all sectors. HQO's goal is to support a more efficient, patient centred health care journey.

Under the *Excellent Care For All Act* enacted June 3, 2010, HQO's mandate was expanded to:

- Recommend and help health care providers adopt evidence based standards of care and best practices;
- Monitor and report on quality improvement efforts across health care sectors; and
- Lead provincial efforts to improve safety, quality, efficiency, and the patient experience across all health care sectors.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(a) Basis of accounting

These financial statements are prepared by management in accordance with Canadian Public Sector Accounting Standards for provincial reporting entities established by the Canadian Public sector accounting board except as noted in 2 (b).

(b) Tangible capital assets

Tangible capital assets purchased with government funding are amortized 100% in the year of acquisition as long as the capital assets have been put to use. This policy is in accordance with the accounting policies outlined in the Ministry of Health and Long-Term Care (MOHLTC) funding guidelines. MOHLTC funding is completely operational and not capital in nature.

(c) Donated materials and services

Value for donated materials and services by voluntary workers has not been recorded in the financial statements. These services are not normally purchased by the organization and their fair value is difficult to determine.

(d) Revenues and expenses

The deferral method of accounting is used. Income is recognized as the funded expenditures are incurred. In accordance with the MOHLTC guidelines, certain items have been recognized as expenses although the deliverables have not all been received yet. These expenses are matched with the funding provided by the Ministry for this purpose.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES *continued*

(e) Measurement uncertainty

The preparation of financial statements in conformity with Canadian Public Sector Accounting Standards requires management to make estimates and assumptions that affect the reporting amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of the revenues and expenses during the period. Estimates are based on the best information available at the time of preparation of the financial statements and are reviewed annually to reflect new information as it becomes available. Measurement uncertainty exists in these financial statements. Actual results could differ from these estimates.

3. DUE TO THE MINISTRY OF HEALTH AND LONG-TERM CARE

In accordance with the MOHLTC financial policy, surplus funds received in the form of grants are recovered by the Ministry of Health subsequent to the year end in which the surplus occurred.

	2013	2012
Excess revenue over expenses in 2011	$ -	$ 9,953
Excess revenue over expenses in 2012	**3,293,331**	3,293,331
Excess revenue over expenses in 2013	**5,532,437**	-
Total repayable at year end	$ **8,825,768**	$ 3,303,284

4. LEASE OBLIGATIONS

There were two property leases in place during the fiscal year: the main location with a lease ending August 31, 2018, and a secondary location whose lease was terminated June 1, 2012. The net annual rent of the main lease is currently $218,746 until March 31, 2015 and will subsequently increase to $301,550 until August 31, 2018. The secondary lease was terminated with a negotiated buyout. This buyout consisted of gross rent for seven months valued at $103,472 including HST. The annual net payments of the remaining rental premise during the next five years of the lease are estimated as follows:

2014	$218,746
2015	$218,746
2016	$301,550
2017	$301,550
2018	$301,550

5. ECONOMIC DEPENDENCE

HQO receives all of its funding from the MOHLTC.

6. FINANCIAL INSTRUMENTS

Fair value The carrying value of cash, accounts payable and accrued liabilities as reflected in the financial position approximate their respective fair values due to their short term maturity or capacity for prompt liquidation. The organization holds all of its cash at one financial institution.

7. COMMITMENTS

On April 1, 2011, upon transfer of the Medical Advisory Secretariat to HQO, an agreement was reached between MOHTLC and HQO. Part of the agreement included severance funding, which included the transfer of funds for severance payments the Ministry would have been required to make to the Association of Management, Administrative and Professional Crown Employees of Ontario (AMAPCEO) for transfered employees under article 38 (AMAPCEO and Crown) had they terminated their employment with the Ministry and not transferred to HQO. The transferred funds included monies owed up to and including April 1, 2011.

An agreement was reached between AMAPCEO and HQO in 2013. HQO's Board ratified this agreement on June 20, 2013. HQO will payout the Termination Payments (as per Article 38) to all employees with a continuous service date of on or before December 31, 2009, at the rate of 1 week per year for each year of service, and prorated for each part year of service. The estimated payout is $60,000 and will occur shortly after June 22, 2013.

8. ONE TIME PROJECTS

Appropriateness:

Performed by the Evidence Standards and Development Branch, Appropriateness work provides the health system with the evidentiary platform needed to support technologies and services. This work generates evidence based analyses and recommendations that discourage the overuse, underuse or misuse of health technologies and services in Ontario. The work is predicted to reduce costs in the health system through the decommissioning and delisting of obsolescent technologies and services.

bestPATH (Person Centred, Appropriate, Timely, Health care)

bestPATH is a suite of HQO designed tools and resources including education and coaching supports drawn from rigorously reviewed evidence, field experience and measurement and evaluation methodology vetted by experts at all levels of Ontario's health care system. HQO makes these tools and resources available to Health Links across the province for them to achieve their common objectives of improved care coordination, care experiences and outcomes for those with complex health conditions.

Residents First

Residents First is a quality improvement initiative to develop the Long-Term Care sector's capacity for quality improvement so that each resident will enjoy safe, effective and responsive care that helps them achieve the highest potential of quality of life.

Integrated Client Care Project – Palliative Care (ICCP)

The project focuses on understanding current gaps in how palliative care is delivered in the Province and provides training, tools and coaching in Quality Improvement science and methodology to support five Local Health Integration Networks(LHIN)/Community Care Access Centre Early Implementation Sites (Mississauga Halton, Toronto Central, Waterloo Wellington, Hamilton Niagara Haldimand Brant, Central West) to create a more effective and integrated system of care for patients.

Behavioural Supports Ontario (BSO)

The BSO Project addresses the needs of older adults with cognitive impairments due to mental health problems, addictions, dementia, or other neurological conditions, who exhibit responsive or challenging behaviours such as aggression, wandering, physical resistance and agitation. HQO supported BSO in the form of LHIN based coaching, facilitation, capacity building and knowledge transfer development and support.

8. ONE TIME PROJECTS *continued*

Web Projects

Web Projects is the result of a multiyear strategy that has put in place a new web infrastructure and launched a new website for HQO that amalgamates the content from HQO's legacy organization sites. The team designs, enhances and implements front and back end systems and applications for both internal and external facing web projects.

SUMMARY OF ONE TIME PROJECTS:

	2013	2012
Appropriateness	$ **646,422**	$ 92,629
bestPATH (Person Centred, Appropriate, Timely, Health care)	**2,685,481**	492,740
Behavioural Supports Ontario	**207,593**	321,401
Integrated Client Care Project	**145,710**	995,603
Residents First	**1,406,042**	4,590,477
Web Projects	**1,280,372**	150,365
Total	$ **6,371,620**	$ 6,643,215

9. SUBSEQUENT EVENTS

HQO has agreed to lease additional space of 6,492 square feet which is expected to be available for occupancy in September 2013. The one time costs are estimated to range from $625,000 to $815,000 and will include moving costs and leasehold improvements. The annual cost of the location is $25.51 per square foot or $165,611 per year.

10. COMPARATIVE FIGURES

The prior period's comparative numbers have been reclassified to reflect the current period's financial presentation.

SCHEDULE OF OPERATIONS COMPARED TO BUDGET FOR THE YEAR ENDED MARCH 31, 2013

	ACTUAL	BUDGET
REVENUE		
Ministry of Health and Long-Term Care	$ 32,205,400	$ 32,205,400
EXPENSES		
Enterprise Strategy and Operations	6,380,660	5,933,908
Integrated Program Delivery	7,201,190	9,979,279
Strategic Partnership and Communications	3,110,644	3,850,614
Health System Performance	2,856,012	3,748,042
Evidence Development & Standards	7,227,349	8,693,557
	26,775,855	32,205,400
EXCESS OF REVENUE OVER EXPENSES	5,429,545	-
INTEREST INCOME	102,892	-
DUE TO THE MINISTRY OF HEALTH AND LONG-TERM CARE	$ 5,532,437	$ -

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